Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 08/01/2024

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
ANSARA CORPORATION

23925 INDUSTRIAL PARK DR
FARMINGTON HILLS, MI 48335-2862

23925 INDUSTRIAL PARK DR
FARMINGTON HILLS, MI 48335-2862

2b Employer Identification Number (EIN)
38-2708433

2c Plan Sponsor's telephone number
248-848-9099

2d Business code (see instructions)
541214

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	02/25/2026	NADIA KHALYLEH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	133
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	133
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	154
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	154
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	154
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 7
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
BLUE CARE NETWORK OF MICHIGAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
38-2359234	95610	126858	180	08/01/2024	07/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
32683	1595

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
13900 LAKESIDE CIRCLE
STERLING HEIGHTS, MI 48313

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	390		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

AMY HALL
423 N MAIN ST
ROYAL OAK, MI 48067

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
32683			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	1210958		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	1210958
b Benefit charges (1) Claims paid	**9b(1)**	1333766		
(2) Increase (decrease) in claim reserves	**9b(2)**	66469		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	1400235
(4) Claims charged			**9b(4)**	1158832
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**	138201		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**	6539		
(F) Charges for risks or other contingencies	**9c(1)(F)**	33724		
(G) Other retention charges	**9c(1)(G)**	105710		
(H) Total retention			**9c(1)(H)**	284174
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	143070
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
BLUE CROSS BLUE SHIELD OF MICHIGAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
38-2069753	54291	126858	52	08/01/2024	07/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
12920	390

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

AMY HALL
423 N MAIN ST
ROYAL OAK, MI 48067

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
12920			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURE PARTNERS OF MI LLC
13900 LAKESIDE CIRCLE
STERLING HEIGHTS, MI 48313

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
390			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	477497		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	477497
b Benefit charges (1) Claims paid	**9b(1)**	923324		
(2) Increase (decrease) in claim reserves	**9b(2)**	23113		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	946437
(4) Claims charged			**9b(4)**	690374
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**	42204		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**	6160		
(F) Charges for risks or other contingencies	**9c(1)(F)**	16497		
(G) Other retention charges	**9c(1)(G)**	36086		
(H) Total retention			**9c(1)(H)**	100947
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	43042
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
72-0977315	68985	915934	154	08/01/2024	08/01/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
820	427

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

CENTRO BENEFITS RESEARCH LLC
325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	429		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
25900 W 11 MILE RD
STE210
SOUTHFIELD, MI 48034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
747	73	ADDITIONAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	5097
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	915935	45	08/01/2024	08/01/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
5102	2356

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

CENTRO BENEFITS RESEARCH LLC
325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	2356		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
25900 W 11 MILE RD
STE 210
SOUTHFIELD, MI 48034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4702	400	ADDITIONAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☒ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	28044
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	915936	27	08/01/2024	08/01/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
2840	1264

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

CENTRO BENEFITS RESEARCH LLC
325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1264		ADDITIONAL COMPENSATION PAID	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
25900 W 11 MILE RD
STE 210
SOUTHFIELD, MI 48034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2626	214	ADDITIONAL COMPENSATION PAID	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	15280
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
72-0977315	68985	915937	163	08/01/2024	08/01/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
17291	8076

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

CENTRO BENEFITS RESEARCH LLC
325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8076			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
25900 W 11 MILE RD
STE210
SOUTHFIELD, MI 48034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
15887	1404	ADDITIONAL COMPENSATION PAID	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	91321
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

A Name of plan
ANSARA CORPORATION HEALTH AND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ANSARA CORPORATION

D Employer Identification Number (EIN)
38-2708433

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
43-0949844	71870	9883208	236	08/01/2024	08/01/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
2113	

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSURED PARTNERS OF MI LLC
25900 W 11 MILE RD
STE210
SOUTHFIELD, MI 48034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2118			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	13720
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

BLUE CARE NETWORK OF MICHIGAN

ERS Final Settlement

for

ANSARA BROTHERS

08/01/2024 - 07/31/2025

CUSTOMER ID: 126858

17-Nov-2025

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: ANSARA BROTHERS

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CARE NETWORK OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2359234
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	95610
(d) CONTRACT OR IDENTIFICATION NUMBER	126858
(e) APPROX. NUMBER OF PERSONS COVERED	180
(f) POLICY OR CONTRACT YEAR FROM	8/1/2024
(g) POLICY OR CONTRACT YEAR TO	7/31/2025

2. INSURANCE FEE AND COMMISSION INFORMATION — (SEE SCHEDULE A ADDENDUM)

3. PERSONS RECEIVING COMMISSIONS AND FEES — (SEE SCHEDULE A ADDENDUM)

PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION — NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (h) Prescription Drug, (k) HMO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:

(i) AMOUNT RECEIVED	$1,210,958
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$1,210,958

(b) BENEFIT CHARGES:

(i) CLAIMS PAID	$1,333,766
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	$66,469
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$1,400,235
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$1,158,832

(c) REMAINDER OF PREMIUM

(i) RETENTION CHARGES

A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$138,201
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$6,539
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$33,724
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$105,710
H. TOTAL RETENTION	$284,174

(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED) — $0

(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR

(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$143,070
(iii) OTHER RESERVES	$0

(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE — $0

10. NONEXPERIENCE-RATED CONTRACTS — NOT APPLICABLE

PART IV: PROVISION OF INFORMATION — (DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Care Network
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	ANSARA CORPORATION
Group Number:	001268580
CID:	126858
Contract Year From:	08/01/2024
Contract Year To:	07/31/2025

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker: ASSUREDPARTNERS OF MI LLC
13900 Lakeside Circle
Sterling Heights, MI 48313-8313

-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$1,594.58
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker: AMY J HALL
423 N Main St
Royal Oak, MI -

-- Amount of Sales and Base Commissions Paid	
-- Fees and Other Commissions Paid Amount	$32,683.34
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	$0.00
-- Service Codes (for Schedule C)	3
	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan	(gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)		3

, -

BLUE CROSS BLUE SHIELD OF MICHIGAN

ERS Final Settlement

for

ANSARA BROTHERS

08/01/2024 - 07/31/2025

CUSTOMER ID: 126858

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

17-Nov-2025

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: ANSARA BROTHERS

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CROSS BLUE SHIELD OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2069753
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	54291
(d) CONTRACT OR IDENTIFICATION NUMBER	126858
(e) APPROX. NUMBER OF PERSONS COVERED	52
(f) POLICY OR CONTRACT YEAR FROM	8/1/2024
(g) POLICY OR CONTRACT YEAR TO	7/31/2025

2. INSURANCE FEE AND COMMISSION INFORMATION — (SEE SCHEDULE A ADDENDUM)

3. PERSONS RECEIVING COMMISSIONS AND FEES — (SEE SCHEDULE A ADDENDUM)

PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION — NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (h) Prescription Drug, (k) PPO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:	
(i) AMOUNT RECEIVED	$477,497
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$477,497
(b) BENEFIT CHARGES:	
(i) CLAIMS PAID	$923,324
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	$23,113
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$946,437
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$690,374
(c) REMAINDER OF PREMIUM	
(i) RETENTION CHARGES	
A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$42,204
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$6,160
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$16,497
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$36,086
H. TOTAL RETENTION	$100,946
(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED)	$0
(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR	
(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$43,042
(iii) OTHER RESERVES	$0
(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE	$0

10. NONEXPERIENCE-RATED CONTRACTS — NOT APPLICABLE

PART IV: PROVISION OF INFORMATION — (DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Cross Blue Shield Michigan
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	ANSARA CORPORATION
Group Number:	007005681
CID:	126858
Contract Year From:	08/01/2024
Contract Year To:	07/31/2025

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	ASSUREDPARTNERS OF MI LLC 13900 Lakeside Circle Sterling Heights, MI 48313-8313
-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$390.44
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	AMY J HALL 423 N Main St Royal Oak, MI -
-- Amount of Sales and Base Commissions Paid	$12,920.45
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan	(gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)		3

, -

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: ANSARA RESTAURANT GROUP

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000915934

3. Date for period: from 2024-08-01 to 2025-08-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid

No Additional Compensation

INSURANCE DATA FOR SCHEDULE A (FORM 5500)
AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: ANSARA RESTAURANT GROUP

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

Unum Life Insurance Company of America

TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 915934

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 154

4. DATE FOR PERIOD: FROM 08-01-2024 TO 08-01-2025

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
AssuredPartners of Michigan, L STE 210 25900 W 11 Mile Rd Southfield MI 48034	747.22	.00	73.16
Centro Benefits Research LLC Ste 300 325 N Kirkwood Rd Kirkwood MO 63122	.00	428.66	.00

6. COVERAGE/BENEFITS PROVIDED: ADD, LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 5,096.61

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ 2.85

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

J7\DM

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: ANSARA RESTAURANT GROUP

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000915935

3. Date for period: from 2024-08-01 to 2025-08-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
No Additional Compensation		

INSURANCE DATA FOR SCHEDULE A (FORM 5500)
AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: ANSARA RESTAURANT GROUP

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

Unum Life Insurance Company of America

TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 915935

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 045

4. DATE FOR PERIOD: FROM 08-01-2024 TO 08-01-2025

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
AssuredPartners of Michigan, L STE 210 25900 W 11 Mile Rd Southfield MI 48034	4,702.46	.00	399.86
Centro Benefits Research LLC Ste 300 325 N Kirkwood Rd Kirkwood MO 63122	.00	2,355.95	.00

6. COVERAGE/BENEFITS PROVIDED: LIFESTYLE LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 28,044.49

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

J7\DM

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: ANSARA RESTAURANT GROUP

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000915936

3. Date for period: from 2024-08-01 to 2025-08-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid

No Additional Compensation

INSURANCE DATA FOR SCHEDULE A (FORM 5500)
AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: ANSARA RESTAURANT GROUP

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

Unum Life Insurance Company of America

TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 915936

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 027

4. DATE FOR PERIOD: FROM 08-01-2024 TO 08-01-2025

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
AssuredPartners of Michigan, L STE 210 25900 W 11 Mile Rd Southfield MI 48034	2,626.23	.00	214.18
Centro Benefits Research LLC Ste 300 325 N Kirkwood Rd Kirkwood MO 63122	.00	1,264.42	.00

6. COVERAGE/BENEFITS PROVIDED: SELECT SHORT TERM DISABILITY

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 15,279.63

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

J7\DM

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: ANSARA RESTAURANT GROUP

1. Name of carrier, service or other organization:

   STARMOUNT LIFE INSURANCE COMPANY

   Tax ID: 720977315 NAIC: 68985

2. Contract Number: 000000915937

3. Date for period: from 2024-08-01 to 2025-08-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
No Additional Compensation		

INSURANCE DATA FOR SCHEDULE A (FORM 5500)
AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: ANSARA RESTAURANT GROUP

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

STARMOUNT LIFE INSURANCE COMPANY

TAX ID: 720977315 NAIC: 68985

2. CONTRACT NUMBER: 915937

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 163

4. DATE FOR PERIOD: FROM 08-01-2024 TO 08-01-2025

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
AssuredPartners of Michigan, L STE 210 25900 W 11 Mile Rd Southfield MI 48034	15,887.33	.00	1,403.61
Centro Benefits Research LLC Ste 300 325 N Kirkwood Rd Kirkwood MO 63122	.00	8,075.81	.00

6. COVERAGE/BENEFITS PROVIDED: DENTAL-STARMOUNT

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 91,321.29

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ 8,595.74

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

J7\DM

Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

Report Start Date	Report End Date
8/1/24	7/31/25

Report Generated: 1/19/26

Payments Received by carrier from plan or plan sponsor:

Name of Plan	Contract or ID #	Enrollment Group	Approximate number of subscribers covered at end of policy or contract year:	Approximate number of subscribers and dependents covered at end of policy or contract year:	EIN	NAIC		Amount
ANSARA RESTAURANT GROUP, INC.	9883208		0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081001	ANSARA 0000	90	175	430949844	71870		$9,603.88
ANSARA RESTAURANT GROUP, INC.	98832081002	ANSARA 0001	1	1	430949844	71870		$70.92
ANSARA RESTAURANT GROUP, INC.	98832081003	ANSARA 0004	3	3	430949844	71870		$212.76
ANSARA RESTAURANT GROUP, INC.	98832081004	ANSARA 0005	3	3	430949844	71870		$206.85
ANSARA RESTAURANT GROUP, INC.	98832081005	ANSARA 0006	3	3	430949844	71870		$299.05
ANSARA RESTAURANT GROUP, INC.	98832081006	ANSARA 0007	2	3	430949844	71870		$205.68
ANSARA RESTAURANT GROUP, INC.	98832081007	ANSARA 0009	2	2	430949844	71870		$141.84
ANSARA RESTAURANT GROUP, INC.	98832081008	ANSARA 0010	1	1	430949844	71870		$76.83
ANSARA RESTAURANT GROUP, INC.	98832081009	ANSARA 0011	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081010	ANSARA 0012	1	1	430949844	71870		$70.82
ANSARA RESTAURANT GROUP, INC.	98832081011	ANSARA 0013	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081012	ANSARA 0014	7	8	430949844	71870		$601.65
ANSARA RESTAURANT GROUP, INC.	98832081013	ANSARA 0015	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081014	ANSARA 0016	2	2	430949844	71870		$141.84
ANSARA RESTAURANT GROUP, INC.	98832081015	ANSARA 0017	3	3	430949844	71870		$212.76
ANSARA RESTAURANT GROUP, INC.	98832081016	ANSARA 0019	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081017	ANSARA 0021	1	1	430949844	71870		$70.92
ANSARA RESTAURANT GROUP, INC.	98832081018	ANSARA 0022	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081019	ANSARA 0023	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081020	ANSARA 0024	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081021	ANSARA 0025	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081022	ANSARA 0026	3	3	430949844	71870		$230.49
ANSARA RESTAURANT GROUP, INC.	98832081023	ANSARA 0027	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081024	ANSARA 0028	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081025	ANSARA 0030	1	1	430949844	71870		$47.28
ANSARA RESTAURANT GROUP, INC.	98832081026	ANSARA 0034	0	0	430949844	71870		$0.00

Note: Payments and applicable fees or commissions related to the plan or plan sponsor, which are not paid and posted within the date range provided above, are not included in this report. Instead, such payments will be included in prior or subsequent Schedule A reporting, as appropriate. Payments and applicable fees or commissions may vary from the carrier's billed amounts.

Vision Insurance Information For Form 5500

ANSARA RESTAURANT GROUP, INC.	98832081027	ANSARA 0035	1	4	430949844	71870		$198.00
ANSARA RESTAURANT GROUP, INC.	98832081028	ANSARA 0036	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081029	ANSARA 0037	0	0				($5.91)
ANSARA RESTAURANT GROUP, INC.	98832081030	ANSARA 0038	1	1	430949844	71870		$30.14
ANSARA RESTAURANT GROUP, INC.	98832081031	ANSARA UNKNOWN	0	0	430949844	71870		$94.56
ANSARA RESTAURANT GROUP, INC.	98832081032	MOTOR CITY PEAKS LLC TOLEDO	1	1	430949844	71870		$94.56
ANSARA RESTAURANT GROUP, INC.	98832081033	MOTOR CITY PEAKS LLC MANAGERS	16	19	430949844	71870		$1,043.78
ANSARA RESTAURANT GROUP, INC.	98832081034	MOTOR CITY PEAKS LLC SOUTHGATE	0	0	430949844	71870		$17.73
ANSARA RESTAURANT GROUP, INC.	98832081035	2BOOLI FARMINGTON HILLS	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081036	2B2G,LLC	0	0				$0.00
ANSARA RESTAURANT GROUP, INC.	98832081037	MOTOR CITY PEAKS AUBURN HILLS, LLC	1	1	430949844	71870		$53.19
ANSARA RESTAURANT GROUP, INC.	98832081038	ROSSFORD RED ROBIN	0	0	430949844	71870		$0.00
ANSARA RESTAURANT GROUP, INC.	98832081039	MOTOR CITY JAM JV LLC	0	0				$0.00
			143	**236**			**Total:**	**$13,719.62**

Commissions or fees paid by carrier to agents, brokers or other persons:

Payee Name	Contract or ID #	Address Line 1	City	State	Zip Code		Amount
AssuredPartners of Michigan, LLC dba J.S	98832081001	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$1,696.96
AssuredPartners of Michigan, LLC dba J.S	98832081002	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$8.73
AssuredPartners of Michigan, LLC dba J.S	98832081003	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$20.07
AssuredPartners of Michigan, LLC dba J.S	98832081004	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$18.89
AssuredPartners of Michigan, LLC dba J.S	98832081005	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$31.10
AssuredPartners of Michigan, LLC dba J.S	98832081006	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$20.52
AssuredPartners of Michigan, LLC dba J.S	98832081007	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$12.98
AssuredPartners of Michigan, LLC dba J.S	98832081008	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$8.26
AssuredPartners of Michigan, LLC dba J.S	98832081010	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$7.08
AssuredPartners of Michigan, LLC dba J.S	98832081012	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$60.17
AssuredPartners of Michigan, LLC dba J.S	98832081014	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$14.16
AssuredPartners of Michigan, LLC dba J.S	98832081015	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$21.25
AssuredPartners of Michigan, LLC dba J.S	98832081017	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$6.49
AssuredPartners of Michigan, LLC dba J.S	98832081022	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$21.85
AssuredPartners of Michigan, LLC dba J.S	98832081025	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$4.13
AssuredPartners of Michigan, LLC dba J.S	98832081027	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$19.80

Note: Payments and applicable fees or commissions related to the plan or plan sponsor, which are not paid and posted within the date range provided above, are not included in this report. Instead, such payments will be included in prior or subsequent Schedule A reporting, as appropriate. Payments and applicable fees or commissions may vary from the carrier's billed amounts.

Vision Insurance Information For Form 5500

AssuredPartners of Michigan, LLC dba J.S	98832081030	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$2.41
AssuredPartners of Michigan, LLC dba J.S	98832081031	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$8.26
AssuredPartners of Michigan, LLC dba J.S	98832081032	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$10.03
AssuredPartners of Michigan, LLC dba J.S	98832081033	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$114.91
AssuredPartners of Michigan, LLC dba J.S	98832081034	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		($1.18)
AssuredPartners of Michigan, LLC dba J.S	98832081037	25900 West Eleven Mile Rd Suite 210	Southfield	MI	48034		$5.90
						Total:	**$2,112.77**

Note: Payments and applicable fees or commissions related to the plan or plan sponsor, which are not paid and posted within the date range provided above, are not included in this report. Instead, such payments will be included in prior or subsequent Schedule A reporting, as appropriate. Payments and applicable fees or commissions may vary from the carrier's billed amounts.